



PARTICIPATION OF FEDERALLY QUALIFIED HEALTH CENTERS IN MEDICAID CASE MANAGEMENT PROGRAMS

NATIONAL
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by L. Carl Volpe and Tim M. Henderson

Health Policy Studies
Center for Policy Research
National Governors' Association

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ISBN 1-55877-161-1

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444 North Capitol Street
Washington, D.C. 20001-1572

Preparation of this document was supported by a Cooperative Agreement with the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services (Project #CSU110002-02-0). Ms. Lynn Spector is the Project Officer.

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Printed in the United States of America.

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Executive Summary

Increasingly, states are using case management to facilitate access to, and increase the efficient delivery of, appropriate care and support services. According to responses from a recent survey of state Medicaid directors by the National Governors' Association (NGA), forty-one states have optionally targeted case management programs for specific populations such as pregnant women and high-risk infants. Case management services to these populations are helping to improve pregnancy outcomes and overall health status. States also can provide case management by applying for 1915(b) freedom-of-choice waivers under provisions of the Social Security Act. Eighteen states have twenty active fee-for-service primary care case management waivers under this section. The case management function under these waivers is to help ensure that services are provided in a cost-effective and efficient manner.

Since case management is a key element of comprehensive and coordinated services provided by federally qualified health centers (FQHCs), NGA's survey also assessed participation by FQHCs in Medicaid case management programs. The study found that of the forty-one states with optionally targeted case management programs, there are twelve states in which FQHCs participate as providers. In those twelve states, FQHCs participate in a total of twenty-one case management programs. These programs are directed primarily toward pregnant women and, to a lesser extent, toward children. Although only twelve states have FQHCs participating in optionally targeted case management, twenty-five states recognize case management activities as an allowable cost within FQHC core services. It is not known why there is not greater FQHC participation in optionally targeted case management programs. However, a previous NGA study suggests that many states initially targeted their case management services toward populations in need of mental health services rather than primary care services.

In contrast to optionally targeted case management services, FQHCs have participated aggressively in primary care case management programs in which providers are reimbursed under a fee-for-service methodology. Of the twenty 1915(b) primary care case management waivers expected to operate under a fee-for-service arrangement, FQHCs are enrolled as providers in seventeen. Participation by FQHCs in these waivers is indicative of successful state efforts to recruit participating providers in medically underserved areas. Because many states define case management as an FQHC core service, FQHCs also should find participation in such programs attractive.



1.

Introduction

Case management to facilitate access to appropriate health care and support services is an integral part of the mission of community and migrant health centers (C/MHCs). Under the grantee provisions of Section 329 and Section 330 of the Public Health Service Act, C/MHCs are required to inform patients “on the availability and proper use of health services” and to initiate “referral to providers of supplemental health services and payment, as appropriate and feasible.” While C/MHCs have had the responsibility to provide case management to their patients, in May 1988 a report of the Senate Committee on Labor and Human Resources concluded that funding constraints had allowed fewer than one-third of these centers to formally provide patient case management, including outreach, counseling, referral, and follow-up services. Further, the committee called for the restoration of these services as additional funds were made available.

Efforts to increase the provision of case management services by C/MHCs began in 1988 when amendments to the Public Health Service Act added patient case management as a distinct service obligation starting in fiscal 1989.¹ In addition, 1991 program guidance to C/MHCs from the Bureau of Health Care Delivery and Assistance (BHCDA) reinforced the mission of these centers to provide case management. Although case management services are required, they are not defined. More broadly, the guidance requires C/MHCs to periodically assess community needs and to establish partnerships with other area providers to ensure the availability and coordination of all necessary health services.

The federal government views case management services as particularly important in providing primary care to high-risk, hard-to-reach populations. Case management is a necessary part of BHCDA’s Infant Mortality Initiative, which funds C/MHCs to develop comprehensive perinatal care programs (CPCPs).² C/MHCs may use these grants to hire case management staff for patient outreach, risk assessment, and education (e.g., informing patients of related health services and helping patients with Medicaid enrollment or transportation services). By the end of fiscal 1989, 263 C/MHCs receiving CPCP grants had added about 300 new staff to provide case management services. Early reports clearly suggest that mothers receiving these services were experiencing improved pregnancy outcomes.³

C/MHCs that receive grants to provide health services to the homeless also are obligated to provide some form of case management under Section 340 of the Public Health Service Act. Added in 1987, grantees must agree to “refer homeless individuals as appropriate” for necessary hospital and mental health services; “provide outreach services to inform homeless individuals of the availability of health services; and aid

homeless individuals in establishing eligibility for assistance, and in obtaining services, under entitlement programs.” About fifty C/MHCs currently receive such funds.

Community and Migrant Health Centers and Medicaid

As Section 329, 330, and 340 grantees, C/MHCs must enroll as both Medicaid and Medicare providers. This requirement ensures that C/MHCs receive reimbursement for services to a portion of the low-income populations they serve. Moreover, enrollment contributes to their financial viability by ensuring access to funds beyond the Public Health Service Act and other grant sources. In 1989 the relationship between C/MHCs and the Medicaid program was strengthened considerably with the establishment of the federally qualified health center (FQHC) program. As FQHCs, C/MHCs (and other providers that can demonstrate that they function like C/MHCs) have special provider status. This status entitles them to receive from Medicaid 100 percent reasonable cost reimbursement for a set of “core” and “other ambulatory services.”

Case Management Services Under the Medicaid Program

Case management can be provided under Medicaid in a number of ways. It can be offered as part of a state’s Medicaid plan or under special program waiver authority. As defined in the *State Medicaid Manual*, Part 4 - Services, Transmittal No. 56, December 1991, case management within the Medicaid program “is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual” (see Appendix A). While case management became an identifiable optional service under Medicaid as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA-85), it has been part of Medicaid since the program’s inception. Prior to COBRA, federal Medicaid matching funds (i.e., federal financial participation) could be claimed for case management activities in four areas:

- as an integral and inseparable component of another service under Medicaid (e.g., home health services);
- as a necessary activity for the effective and efficient administration of the Medicaid program (e.g., utilization review or inpatient prior authorization);
- as a service granted under a waiver of Section 1915(b) of the Social Security Act; or
- as a service granted under a waiver of Section 1915(c) of the Social Security Act.

Section 1915(c) waivers, known as home- and community-based services (HCBS) waivers, allow states to provide services in the home or in the community to persons who meet the criteria for placement in an institution but who could be served at home or in the community. HCBS waivers are used to provide community services to the frail elderly and disabled, to persons with mental retardation, and to a lesser extent, to persons with acquired immune deficiency syndrome (AIDS). Under a HCBS waiver a package of services typically is made available to the recipient. While case management is not a required service under the waiver, it may be included in the package. In

fact, case management is one of the services most often provided, regardless of the population served. The state is required to show that the HCBS package is no more expensive than is the cost of institutionalization.

The popularity of HCBS waivers increased during the last decade. As of January 1992, forty-eight states operated a total of 175 HCBS waivers—an increase of twenty-two waivers since July 1990.

Optionally Targeted Case Management. The case management services option was added to the list of optional Medicaid services under COBRA (P.L. 99-272). It is commonly referred to as “optionally targeted case management” (OTCM). According to the *State Medicaid Manual*, case management is defined “as services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.” The manual identifies the following as activities that would be inappropriate and not available for federal financial participation if provided under OTCM:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services and utilization review; and
- Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system).

OTCM providers are explicitly prohibited from limiting or restricting access to other services available to the recipient under the state’s Medicaid plan.

OTCM is unique among the optional services within the Medicaid program in several important ways:

- *Case management may be targeted to specific populations.* Unlike other services that must be offered to all eligible Medicaid recipients, states have broad latitude to target or limit case management services to specific populations. Targeting may be done by age, type or degree of disability, illness, or condition. For example, a state may choose to provide services only to high-risk pregnant women, high-risk infants, persons with hemophilia, or persons with AIDS or AIDS-related disorders. Targeting may be done without any special waivers.
- *Case management may be targeted to specific geographic locations.* Under the OTCM option, the case management service may be limited to specific geographic regions or political subdivisions of a state. Again, unlike a typical optional service that must be made available statewide, targeting to specific locations within a state may be done without waivers.
- *Case management may differ within a state for different populations.* If case management services are offered to different populations within a state, the type of case management activities may differ to serve the unique needs of each population, notwithstanding certain federal parameters.

However, like other optional services, recipients must have the option to refuse OTCM services and they must have a choice of providers. With the exception of OTCM for persons with developmental disabilities or chronic mental illness, a state may not limit the providers of the service. Any provider that meets the criteria for providing OTCM must be permitted to do so.

OTCM and the Early and Periodic Screening, Diagnostic, and Treatment Program. Under Medicaid, states must provide a separate set of preventive, diagnostic, and treatment services to all persons below age twenty-one. This is called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Prior to 1989, states could select from among the optional services those services to be provided under EPSDT. States could have provided select services only to participants of EPSDT programs without offering these services to the rest of the Medicaid population. However, as a result of the Omnibus Budget Reconciliation Act of 1989, states now are required to provide all medically necessary services identified in an EPSDT screen, provided those services are permitted under federal regulations and even if the state has not elected to provide such optional services. Because OTCM is authorized in the Social Security Act, OTCM services are not subject to this provision of the 1989 law. (Such services are not included in the section of the act listing the services that must be provided to EPSDT recipients if deemed medically necessary.)

Case Management Under Section 1915(b) Freedom-of-Choice Waivers. Another way to provide case management to Medicaid recipients is available under Section 1915(b) of the Social Security Act. Case management under these waivers helps ensure that services are provided in a cost-effective and efficient manner. In Medicaid terminology, the 1915(b) waivers permit states to limit the freedom of choice of providers for recipients. These programs operate similar to those of health maintenance organizations and other prepaid health care organizations in the private sector. Except for family planning and emergency services, the primary care provider serves as the first source of care for the recipient and as a "gatekeeper." This provider makes referrals for medically necessary specialty care and often makes prior authorization decisions for inpatient hospital care.

States must make specific application for a 1915(b) waiver. Waiver approval resides with the Health Care Financing Administration (HCFA). The allowable services and provider qualifications are articulated in the waiver application. States must define the range and amount of services that will be available under the waiver and may restrict services to specific target populations and geographic locations. They also must ensure that the waiver will result in cost-effective and efficient service provision. States must demonstrate both in their application and subsequent documentation that the cost of services under the waiver is no greater than if the services were provided to recipients under the regular Medicaid program.

Primary care providers are required to offer recipients access to care twenty-four hours a day, seven days a week. Access to a knowledgeable and responsible party must be available either in person or by telephone. A recipient selects or is assigned a primary care provider, and both the recipient and the provider are made aware of the provider/patient relationship. As a condition for waiver approval, states must establish clear mechanisms for the selection of a provider and disenrollment by the recipient to ensure nondiscrimination.

States may apply for 1915(b) freedom-of-choice waivers under four provisions of the Social Security Act. The following descriptions are excerpted from the HCFA report, *Section 1915(b) Waivers—Guide to Best Practices* (see Appendix B).

- *Section 1915(b)(1)—Primary Care Case Management Systems (PCCM) or Specialty Physician Services Arrangements.* Under a PCCM waiver, the state must ensure that a specific person, persons, or provider will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitative services on behalf of program recipients. Typically, the providers of primary care are family practice physicians, internists, pediatricians, obstetricians, or mid-level practitioners such as physician assistants and nurse practitioners.
- *Section 1915(b)(2)—Locality as a Central Broker.* A waiver under this provision of the act permits a locality (i.e., any defined local jurisdiction) to act as a central broker (i.e., agent, facilitator, or negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide recipients with more information about the range of health care options available to them. In practice this waiver is used in conjunction with a 1915(b)(1) waiver to help recipients choose among the options available to them under that waiver program.
- *Section 1915(b)(3)—Sharing of Cost Savings with Recipients.* Under this provision, states may share cost savings resulting from the use of more cost-effective medical care with recipients by providing them with more services. Additional services may include those not identified in the current state plan, or the elimination of copayments, deductibles, or service limitations. This waiver also is used in conjunction with 1915(b)(1) waivers.
- *Section 1915(b)(4)—Restriction of Recipients to Specified Providers.* Under this provision, states may require recipients to obtain services only from providers that commit to provide such services and meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provision of covered care services. For example, this waiver may be requested if a state has an adequate supply of providers and wants to establish contracts with certain providers for a given type of service at a rate lower than that established under the normal state plan, or wants to have the covered waiver population choose between two or more health maintenance organization providers.

Besides the traditional fee-for-service reimbursement methodology, Medicaid also permits contracting arrangements that include capitation and risk-based plans. Specifically, Medicaid recognizes three contracting arrangements:

- *Health Maintenance Organization (HMO).* An HMO is an entity that has a risk contract to provide or ensure the delivery of comprehensive services to an enrolled group of persons under a prepaid fixed sum or capitation arrangement.
- *Health Insuring Organization (HIO).* An HIO is an entity that assumes an underwriting risk to pay for medical services provided to recipients in

exchange for a premium or subscription charge paid to the state. HIOs do not assume medical responsibility for individual services.

- *Prepaid Health Plan (PHP)*. A PHP is an entity that offers less than comprehensive services on a prepaid or other risk basis or comprehensive services on a nonrisk or cost basis.

Any of these arrangements may be included in 1915(b) waivers. As of 1992, twenty-eight states had 1915(b) waivers. Individuals most often covered under these waivers are those eligible through the Aid to Families with Dependent Children (AFDC) program.

2.

Purpose of the Study

Case management is a key element of comprehensive and coordinated services at community and migrant health centers. Moreover, C/MHCs have several options to receive Medicaid reimbursement for certain case management activities. The Bureau of Health Care Delivery and Assistance contracted with the National Governors' Association to examine the participation of C/MHCs as FQHCs in providing case management under Medicaid.

The study was restricted to participation in optionally targeted case management programs and 1915(b) primary care case management (PCCM) waivers in which providers are reimbursed using a fee-for-service methodology. PCCM waivers also may use fully and partially capitated reimbursement as well as a variety of risk sharing arrangements. Capitated and risk sharing PCCM models are infinitely more complex. While some C/MHCs participate in such waivers, regulatory guidance on the relationship between C/MHCs as FQHCs and these models currently is under development, and significant ambiguity exists. For this reason, the study limited its examination of PCCM waivers to those using fee-for-service reimbursement.

The study was designed to collect the most comprehensive and current information available in all fifty states and the District of Columbia. For the assessment of FQHC participation in Medicaid optionally targeted case management programs, a survey instrument was sent to each Medicaid director. Data were collected on the presence of OTCM within the state's Medicaid program. Moreover, the survey sought to identify those OTCM programs in which FQHCs are participating as providers and the reimbursement characteristics of the participating FQHCs in case management activities.

With the assistance of staff from the Medicaid Bureau at the Health Care Financing Administration, twenty active fee-for-service PCCM waivers were identified. Data on the participation of FQHCs were obtained through a telephone interview.

3.

Study Results

Fifty of the fifty-one Medicaid directors responded to the OTCM mail survey. Staff from all twenty PCCM programs participated in the telephone survey. The results of the survey are presented in Tables 1 through 4 in the following sections. Note that the District of Columbia is counted as a state in summary statistics.

Optionally Targeted Case Management Programs

Forty-one states reported having OTCM programs, while nine states reported having no such programs (see Table 1). Of the forty-one states with OTCM programs, twelve reported that FQHCs participate as providers in at least one OTCM program. Three states reported that they plan to add FQHC providers in the future, while one state reported that the participation of FQHCs is under consideration.

FQHC Participation in OTCM. Table 2 contains a state-by-state description of the twelve states where FQHCs participate as providers. In seven of the twelve states FQHCs participate in more than one OTCM program. In total, FQHCs participate in twenty-one case management programs. Most noteworthy is that in all twelve states, FQHCs participate in some type of case management program for pregnant women. In three states—Maryland, Missouri, and Washington—case management is provided to infants. Among these three states, case management is limited to high-risk infants in all but Washington. In Alabama, Maryland, and Massachusetts, FQHCs participate as providers for persons with AIDS. Alabama also provides case management to persons who are HIV-positive. Finally, FQHCs in New Mexico provide case management to persons who are chronically mentally ill or to adults with developmental disabilities.

The OBRA-89 legislation establishing FQHCs defines a set of “core services” that may be provided by FQHCs and a second service category called “other ambulatory services.” It is expected that C/MHCs will receive 100 percent reasonable cost reimbursement for services in both categories. Among the twenty-one OTCM programs in which FQHCs participate, OTCM is considered a core service in seven and an other ambulatory service in fourteen. One state (Montana) divides the case management services so that some are considered core services and others are deemed other ambulatory services. Excluding Montana, states are more likely to reimburse services at a separate service rate than as part of an all-inclusive rate. In nineteen of the twenty-one programs, FQHCs are reimbursed at 100 percent of reasonable cost. In the other two programs, FQHCs are paid the same as non-FQHC providers.

Table 1

**Medicaid Optionally Targeted Case Management and
Participation of Federally Qualified Health Centers**

	Does the Medicaid Program Offer Optionally Targeted Case Management?	Are FQHCs Enrolled as Qualified Providers of Optionally Targeted Case Management?
Alabama	Yes	Yes
Alaska	No	n/a
Arizona	No	n/a
Arkansas	Yes	No
California	NR	NR
Colorado	Yes	No
Connecticut	Yes	No
Delaware	No	n/a
District of Columbia	No	n/a
Florida	Yes	No
Georgia	Yes	Yes
Hawaii	Yes	No
Idaho	Yes	No
Illinois	No	n/a
Indiana	Yes	No
Iowa	Yes	No
Kansas	Yes	No*
Kentucky	Yes	No
Louisiana	Yes	Adding in the Future
Maine	Yes	No
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	No
Minnesota	Yes	No
Mississippi	No	n/a
Missouri	Yes	Yes
Montana	Yes	Yes
Nebraska	Yes	No
Nevada	Yes	No
New Hampshire	No	n/a
New Jersey	Yes	No
New Mexico	Yes	Yes
New York	Yes	Yes
North Carolina	Yes	Yes
North Dakota	Yes	No
Ohio	Yes	Yes
Oklahoma	Yes	No
Oregon	Yes	Adding in the Future
Pennsylvania	Yes	No
Rhode Island	Yes	No
South Carolina	Yes	Yes
South Dakota	No	n/a
Tennessee	Yes	No
Texas	Yes	Adding in the Future
Utah	Yes	No
Vermont	Yes	No
Virginia	Yes	No
Washington	Yes	Yes
West Virginia	Yes	No
Wisconsin	Yes	No
Wyoming	No	n/a

NOTES: n/a - not applicable. NR - no response. *- under consideration.

SOURCE: National Governors' Association, 1992.

Table 2
Service, Rate, and Reimbursement Characteristics
of Federally Qualified Health Centers in
Medicaid Optionally Targeted Case Management Programs

State	Case Management Target Populations	FQHC Service Category		FQHC Rate Category		Reimbursement	
		Part of Core Services	Other Ambulatory Service	Inclusive Rate	Separate Service Rate	100% Reasonable Cost	How Does Reimb. Compare Between FQHC and non-FQHC?
Alabama	Persons with AIDS or HIV- positive Pregnant women	X	X	X	X	Yes Yes	FQHC may be greater FQHC may be greater
Georgia	Pregnant women Children		X X		X X	Yes Yes	May be greater or less May be greater or less
Maryland	Pregnant women High-risk infants Persons with AIDS	X X		X X		Yes Yes No	FQHC rate is greater FQHC rate is greater Equal
Massachusetts	Substance-abusing pregnant women Persons with AIDS		X X		X X	Yes Yes	Equal Equal
Missouri	Pregnant women High-risk infants	X X			X X	Yes Yes	FQHC rate is greater FQHC rate is greater
Montana (a)	High-risk pregnant women	X	X	X	X	Yes	FQHC rate is greater

Table 2

**Service, Rate, and Reimbursement Characteristics
of Federally Qualified Health Centers in
Medicaid Optionally Targeted Case Management Programs
(continued)**

State	Case Management Target Populations	FQHC Service Category		FQHC Rate Category		Reimbursement	
		Part of Core Services	Other Ambulatory Service	Inclusive Rate	Separate Service Rate	100% Reasonable Cost	How Does Reimb. Compare Between FQHC and non-FQHC?
New Mexico (b)	Pregnant women		X	X		Yes	May be greater or less
	Chronically mentally ill		X	X		Yes	May be greater or less
	Adults with developmental disabilities		X	X		Yes	May be greater or less
New York (c)	Pregnant and postpartum women		X		X	No	Equal
North Carolina	Pregnant women		X	X		Yes	FQHC rate is greater
Ohio	Pregnant women	X		X		Yes	FQHC rate is greater
South Carolina	At-risk pregnant women		X		X	Yes	Equal
Washington	Pregnant women		X		X	Yes	FQHC rate is greater
	Children up to age one		X		X	Yes	FQHC rate is greater

NOTES: (a) The nurse practitioner and social work components of case management are reimbursed as a core service. Nutritional services are reimbursed as other ambulatory services.

(b) The FQHC encounter rate varies greatly from clinic to clinic, so rates may be greater or less than non-FQHC providers.

(c) FQHC and non-FQHC providers are reimbursed under the same cost-related methodology.

SOURCE: National Governors' Association, 1992.

Case Management Activities Outside of OTCM Programs

As a result of OBRA-89, states may choose to recognize case management activities as an allowable cost within FQHC core services regardless of whether the FQHC participates in an OTCM program. Table 3 identifies the states that recognize case management activities within core services. Of the fifty states responding to the survey, half (twenty-five) permit case management activities as an allowable cost, twenty-three do not, and two states have not yet determined whether to do so. Of the forty-one states that offer optionally targeted case management programs, twenty-two permit case management activities as an allowable core services cost. Of the twelve states where FQHCs participate in OTCM, six states do not permit case management activities as an allowable cost.

Primary Care Case Management Waivers

Of the twenty 1915(b) primary care case management (PCCM) waivers that were expected to operate under a fee-for-service model, FQHCs are enrolled as providers in seventeen.⁴ FQHCs do not participate in Georgia's Pregnant Women Substance Abuse Day Treatment Program, Minnesota's Chemical Dependency Treatment Fund, or Tennessee's Memphis Pediatric Case Management Project. With regard to the Georgia and Minnesota programs, FQHCs are not excluded from participation, but to date none has expressed an interest in participating. The Tennessee waiver, by contrast, only permits enrollment by private physicians. Table 4 contains a description of all waiver programs participating in the study.

FQHC Participation in PCCM Waivers. Under Medicaid statutes and regulations, PCCM waivers include both case management and direct service delivery. FQHCs participate under this structure in several ways. In the vast majority of waivers, FQHCs provide both case management and direct service delivery. However, in two waivers, Illinois' Medicaid Partnership Initiative and South Carolina's High Risk Channeling Project, FQHCs provide only direct services. In Illinois, a partnership that coordinates the program is responsible for providing ongoing case management. FQHCs may, however, screen patients on their need for case management services. In South Carolina, case management is provided only by case managers from health departments.

In three states—Colorado, Kentucky, and Michigan—the Medicaid agency expressed concern about having the recipient linked directly to a physician rather than a clinic. In Colorado the recipient must be assigned directly to an FQHC physician. In Kentucky such an assignment is encouraged but not required.

FQHC Reimbursement. With the exceptions of Alabama's global fee and Missouri's negotiated capitated rate, all of the FQHCs are reimbursed at 100 percent reasonable cost for all services they deliver directly. In nine waiver programs the FQHC receives a monthly fee for each recipient participating in the program. That fee ranges from \$2 per month per recipient to \$20 per month per recipient for case management of a target population. In five programs the case management fees are included in the all-inclusive encounter rate to the FQHC.

Table 3

**Are Case Management Activities Permitted
as Allowable Costs Within FQHC Core Services?**

Alabama	Yes
Alaska	No
Arizona	No
Arkansas	Yes
California	NR
Colorado	Yes
Connecticut	Yes
Delaware	No
District of Columbia	Yes
Florida	Yes
Georgia	No
Hawaii	Yes
Idaho	Yes
Illinois	Yes
Indiana	No
Iowa	Undetermined
Kansas	No
Kentucky	Yes
Louisiana	No
Maine	No
Maryland	Yes
Massachusetts	No
Michigan	Yes
Minnesota	No
Mississippi	Undetermined
Missouri	Yes

Montana	Yes *
Nebraska	No
Nevada	No
New Hampshire	No
New Jersey	Yes
New Mexico	Yes
New York	No
North Carolina	Yes
North Dakota	No **
Ohio	No
Oklahoma	Yes
Oregon	Yes ***
Pennsylvania	Yes
Rhode Island	No
South Carolina	No
South Dakota	No
Tennessee	Yes
Texas	No
Utah	Yes
Vermont	No
Virginia	No
Washington	No
West Virginia	Yes
Wisconsin	Yes
Wyoming	Yes

NOTES: NR - no response.

* As selected components of optionally targeted case management for high-risk pregnant women.

** State has only one FQHC that has not enrolled in the Medicaid program to date.

*** Provided as extended services only to pregnant women.

SOURCE: National Governors' Association, 1992.

Table 4
Federally Qualified Health Centers and
1915(b) Primary Care Case Management Waivers

	Waiver Characteristics [a]	FQHC Participation	FQHC Reimbursement
Alabama	<i>Maternity Waiver Program</i> * Waiver type: 1915(b)(1), (3), and (4). * Mandatory for all pregnant women in designated counties. * Maternity-related services, including prenatal care, delivery, postpartum care, case management, transportation, and other services.	Yes.	FQHCs receive an enhanced global fee that is the same as the fee paid to non-FQHC providers.
Colorado	<i>Primary Care Case Management Program</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and SSI recipients. * All state plan services. [b]	Yes. Recipients served within FQHCs must be assigned a specific physician within the clinic.	FQHCs reimbursed under an encounter rate at 100% reasonable cost. There is no separate fee for case management services.
Florida	<i>Medicaid Physician Access System (MediPASS)</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients in 4 counties except for HMO enrollees. * All state plan services. [b]	Yes.	FQHCs receive \$3 per month per recipient with all other services reimbursed at 100% reasonable cost. Monthly recipient fee is reflected in the cost report in order to prevent duplicative payments.
Georgia	<i>Pregnant Women Substance Abuse Day Treatment Program</i> * Waiver type: 1915(b)(1), and (4). * Voluntary participation for pregnant alcohol and substance abusers in selected areas of state. * Treatment for addiction either provides or arranges for prenatal care, postpartum care, and other auxiliary services required for mothers and children.	No.	Not applicable.

Table 4
Federally Qualified Health Centers and
1915(b) Primary Care Case Management Waivers
(continued)

	Waiver Characteristics [a]	FQHC Participation	FQHC Reimbursement
Illinois	<i>Medicaid Partnership Initiative</i> * Waiver type: 1915(b)(1) and (3). * Voluntary for pregnant women and children up to age 22, persons with AIDS, mental illness, disabilities, and chronic conditions in West Chicago and East St. Louis. * Primary care, case management, and client education services.	Yes. A "partnership" oversees the waiver in each location and has responsibility for ongoing case management. FQHCs provide direct care as well as screening for case management.	FQHCs receive 100% reasonable cost reimbursement for services as well as fees for case management referrals to the "partnership." Referral fees are to be reflected in cost reports so that payment is not made twice.
Iowa	<i>Medicaid Patient Access to Service System (MediPASS)</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients in 7 counties except for HMO and PHP enrollees. * All state plan services. [b]	Yes.	FQHCs receive 100% reasonable cost reimbursement for services. Case management services are built into the rate.
Kansas	<i>Primary Care Network</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients in seven counties. * All state plan services. [b]	Yes.	FQHCs receive \$2 per month per recipient with all other services reimbursed at 100% reasonable cost in an encounter rate.
Kentucky	<i>Kentucky Patient Access and Care System</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients in nearly all counties. * All state plan services. [b]	Yes. FQHC clinics are encouraged to assign recipients to specific physicians, however, it is not a requirement.	FQHCs receive \$3 per month per recipient with all other services reimbursed at 100% reasonable cost.

Federally Qualified Health Centers and 1915(b) Primary Care Case Management Waivers

(continued)

	Waiver Characteristics [a]	FQHC Participation	FQHC Reimbursement
Maryland	<i>Medical Access to Care Program (MAC)</i> * Waiver type: 1915(b)(1). * Mandatory for categorically needy, except for HMO enrollees or other managed care program participants, dual Medicaid/Medicare-eligibles, recipients of time-limited eligibility, and residents of long-term care facilities. * Most state plan services.	Yes.	FQHCs receive 100% reasonable cost reimbursement for services.
Maryland	<i>Diabetes Care Program</i> * Waiver type: 1915(b)(1) and (3). * Voluntary -- Open to recipients who have been hospitalized for a diabetes-related condition. * All state plan services, plus special diabetes-related preventive care not available under the state plan.	Yes.	FQHCs receive \$20 per month per recipient with all other services reimbursed at 100% reasonable cost.
Michigan	<i>Primary Care Physician Sponsor Program</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients in one county. * All state plan services.	Yes. The waiver program does not explicitly enroll FQHCs, but FQHC physicians are enrolled.	FQHC physicians receive \$3 per recipient per month as well as 100% reasonable cost reimbursement for all other services. Monthly recipient fee is reflected in cost reports so that payment is not made twice.
Minnesota	<i>Chemical Dependency Treatment Fund</i> * Waiver type: 1915(b)(1) and (4). * Voluntary for chemically dependent recipients. * Case management, primary care, outpatient care, extended and transitional rehabilitative services.	No.	Not applicable.

Table 4
Federally Qualified Health Centers and
1915(b) Primary Care Case Management Waivers
(continued)

	Waiver Characteristics [a]	FQHC Participation	FQHC Reimbursement
Missouri	<i>Managed Health Care Program</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients in Jackson County. * All state plan services. [b]	Yes. The waiver program has both fee-for-service and prepaid capitated components. FQHCs participate within the prepaid part of the waiver.	FQHCs have a negotiated capitated rate. The rate does not reflect 100% reasonable cost reimbursement.
New Mexico	<i>Primary Care Network</i> * Waiver type: 1915(b)(1). * Mandatory for all recipients in participating areas, with exceptions. * All state plan services, with exceptions.	Yes.	FQHCs receive \$2 per month per recipient with all other services reimbursed at 100% reasonable cost.
North Carolina	<i>Patient Access and Coordinated Care (Carolina ACCESS)</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related, Medicaid-indigent children, and aged, blind, and disabled in specific counties. * All state plan services. [b]	Yes.	FQHCs receive \$3 per recipient per month as well as 100% reasonable cost reimbursement for all other services. Monthly recipient fee is reflected in cost reports so that payment is not made twice.
South Carolina	<i>High Risk Channeling Project (HRCP)</i> * Waiver type: 1915(b)(1), (3), and (4). * Mandatory for high-risk pregnant women and children. * Case management and all maternity-related medical care, nutritional and social work assessments, and health education.	Yes. However, under the waiver FQHCs provide direct care but are not permitted to provide case management. Two FQHCs provide social work and special nutritional counseling.	FQHCs receive 100% reasonable cost for all direct services (encounter rate). Social work and nutritional counseling are paid as an "other ambulatory service" at 100% reasonable cost.

Table 4
Federally Qualified Health Centers and
1915(b) Primary Care Case Management Waivers
 (continued)

State	Waiver Characteristics [a]	FQHC Participation	FQHC Reimbursement
South Carolina	<i>Mental Health Case Management</i> * Waiver type: 1915(b)(1) and (4). * Mandatory, but restricted to 160 Medicaid-eligible SSI recipients who are mentally ill, noninstitutionalized individuals between the ages of 22 and 64. * Medical care and mental health services.	Yes. FQHCs participate in the delivery of medical care as well as case management. Mental health services are provided by mental health departments.	FQHCs receive \$5 per recipient per month as well as 100% reasonable cost reimbursement for all other services. Monthly recipient fee is viewed as an add-on. Case management activities also may be reflected and reimbursed through cost reports.
Tennessee	<i>Memphis Pediatric Case Management Project</i> * Waiver type: 1915(b)(1). * Voluntary for children in Shelby County. * All state plan services.	No.	Not applicable.
Utah	<i>Choice of Health Care Delivery Programs</i> * Waiver type: 1915(b)(1) and (2). * Mandatory in specified counties for all Medicaid recipients, except long-term care recipients in foster care settings. * All state plan services. [b]	Yes.	FQHCs receive 100% reasonable cost reimbursement for services. Case management fees are built into the rate.
West Virginia	<i>Physician Assured Access System (PAAS)</i> * Waiver type: 1915(b)(1). * Mandatory for AFDC and AFDC-related recipients. * All state plan services.	Yes.	FQHCs receive \$3 per month per recipient with all other services reimbursed at 100% reasonable cost.

NOTES: [a] Excerpted from Section 1915(b) Waivers--Guide to Best Practices, by Health Care Financing Administration, Medicaid Bureau, 1992.

[b] Where "all state plan services" are listed as offered under the waiver program, it should be noted that in nearly every case this does not include items and services such as long-term care, dental services, and eyeglasses.

SOURCE: National Governors' Association, 1992.

Attitudes Toward FQHC Participation in PCCM Waivers. Of the seventeen waiver programs in which FQHCs participate, thirteen identified specific benefits of having FQHCs participate. In several cases more than one benefit was identified. Providing access to care in areas of poor provider participation is foremost among the benefits reported by waiver managers (five respondents). At least one manager reported that the program could not exist without FQHC participation. Program managers reported that the quality of care at FQHCs is better than that provided by private physicians. Three managers reported that FQHCs are a great source of care for the poor; one reported that the care is "holistic." Two managers reported that FQHCs' case management activities are much better; one noted that recipients often select the FQHC. FQHCs are better able to contain costs, have a better staffing ratio, and go the "extra mile" with recipients, according to one waiver manager.

No trend was apparent among the problems identified by waiver managers. In two cases the managers thought that the staffing ratio could improve. There was one report of FQHCs having trouble meeting the twenty-four-hour availability requirement, and one report of problems with monitoring physician participation and utilization since recipients were not assigned to a specific physician at the FQHC. Finally, in one case the manager reported that having to reimburse at 100 percent of reasonable cost is expensive and makes it difficult to demonstrate the waiver cost-effectiveness criterion.

4.

Discussion

In 1986 case management services were added to the established Medicaid program. This modification makes it easier to serve certain Medicaid populations but not provide these services statewide. It also has contributed to the proliferation of case management services among states. As the data from this study show, forty-one states have OTCM services in their plan. Moreover, while optionally targeted case management programs are commonly found in state Medicaid programs, relatively few FQHCs are enrolled as qualified providers. When states do permit FQHC participation, the case management activities are directed primarily toward pregnant women and, to a lesser extent, toward children.

It is not known exactly why more FQHCs do not participate in optionally targeted case management programs. However, data collected by the National Governors' Association in 1988 suggest that a large number of states initially targeted their case management services toward persons with chronic mental illness or mental retardation. For both of these target groups, states may be restricting the provider base. In a number of states the provider population is limited to existing public and quasi-public community-based organizations (e.g., community mental health organizations). At best, this is only a partial answer. It is worth noting that besides programs for persons with chronic mental illness and persons with mental retardation, states may not restrict the type of provider that may enroll in the program. Data from the current study suggest that centers can and do participate in case management services, especially for pregnant women and children, and more FQHCs should consider participating in the program.

Notwithstanding the problems in participation, the data suggest that states are complying with the statutory requirements for reimbursement of C/MHCs as FQHCs. Finally, although only twelve states have FQHCs participating in OTCM, twenty-five states do recognize case management activities as an allowable cost within FQHC core services.

In contrast to optionally targeted case management services, FQHCs are aggressively participating in primary care case management programs in which providers are reimbursed under a fee-for-service methodology. A vast majority provide both case management and direct treatment services, and most are reimbursed at 100 percent reasonable cost. Thirteen of the seventeen PCCM programs that use FQHCs realize unique benefits from FQHC participation. Most notable is recipients' increased access to care in areas where Medicaid historically has had trouble finding and keeping

providers. In general, these data suggest an important role for FQHCs in providing coordinated care under the Medicaid program. The role of FQHCs in Medicaid capitated and risk sharing plans has yet to be explored. Without such data, the important relationship between FQHCs and Medicaid managed care cannot be fully understood.

Endnotes

1. U.S. House of Representatives, Committee on Energy and Commerce, *Compilation of Selected Acts Within the Jurisdiction of the Committee on Energy and Commerce: Health Law* (Washington, D.C.: U.S. Government Printing Office, August 1991).
2. In 1990 Infant Mortality Initiative grants were folded into the total appropriation for community and migrant health centers. A small proportion of these funds are still awarded separately. In fiscal 1990, 275 centers received about \$31 million in CPCP funds.
3. National Clearinghouse for Primary Care Information, *Primary Care Perspectives Special Issue: Case Management* (McLean, Virginia: National Clearinghouse for Primary Care Information, February 1990).
4. Two of the PCCM waivers, though identified as fee for service, operated under different reimbursement rules. In Alabama's Maternity Waiver Program providers are reimbursed under a global fee. In Missouri's Managed Health Care Program private physicians are reimbursed under a fee-for-service methodology but participating federally qualified health centers are reimbursed through a negotiated capitated rate.



Appendixes



Appendix A
State Medicaid Manual, Part 4—Services



state medicaid manual

Part 4 — Services

Department of Health
and Human Services
Health Care Financing
Administration

Transmittal No. 56

Date DECEMBER 1991

<u>REVISED MATERIAL</u>	<u>REVISED PAGES</u>	<u>REPLACED PAGES</u>
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Sec. 4302 - 4302.3(Cont.)	4-305 - 4-317 (13 pp.)	4-305 - 4-314 (10 pp.)

CLARIFICATION--EFFECTIVE DATE: NOT APPLICABLE

Section 4302, Optional Targeted Case Management Services--Basis, Scope and Purpose, clarifies the definition of case management.

Section 4302.2, State Plan Amendment Requirements, clarifies (1) a recipient's free choice of qualified providers; (2) participating providers must maintain case records for all recipients; (3) the extent to which States may establish reasonable provider qualifications without restricting a recipient's freedom of choice; (3) the exception to FFP reimbursement for services for which another payer is liable; (4) the distinction between targeted case management services and case management type activities for which administrative Federal match may be claimed; and (5) case management under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. It also provides (1) examples of target groups currently receiving case management services under §1915(g) of the Act and (2) information that must be provided in the payment methodology description. While HCFA has previously requested the payment methodology for public as well as private providers, this requirement was not previously included in this section.

Section 4302.3, Instructions for Completing Preprint Supplement, adds a requirement to include the unit(s) of service.

HCFA-Pub. 45-4



PART 4
SERVICES

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4302. OPTIONAL TARGETED CASE MANAGEMENT SERVICES - BASIS, SCOPE AND PURPOSE

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added §§1915(g)(1) and (g)(2) to the Act. These sections add optional targeted case management services to the list of services that may be provided under Medicaid. Section 1895(c)(3) of the Tax Reform Act of 1986 (P.L. 99-514) added case management services to the list of services in §1905 of the Act. Section 4118(i) of OBRA 1987 (P.L. 100-203) added a section discussing the qualifications of case managers for individuals with developmental disabilities or chronic mental illness. Both the Tax Reform Act and OBRA 1987 amendments are effective as if included in COBRA and are considered effective on April 7, 1986.

A. Background.--Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Prior to the enactment of P.L. 99-272, States could not provide case management as a distinct service under Medicaid without the use of waiver authority. However, aspects of case management have been an integral part of the Medicaid program since its inception. The law has always required interagency agreements under which Medicaid patients may be assisted in locating and receiving services they need when these services are provided by others. Prior to the enactment of P.L. 99-272, Federal financial participation (FFP) for case management activities may be claimed in any of four basic areas:

1. Component of Another Service.--Case management may be provided as an integral and inseparable part of another covered Medicaid service. An example of this type of case management is the preparation of treatment plans by home health agencies. Since plan preparation is required as a part of home health services, separate payment for the case management component cannot be made, but is included in the payment made for the service at the Federal Medical Assistance Percentage (FMAP) rate.

2. Administration.--Case management may be provided as a function necessary for the proper and efficient operation of the Medicaid State plan, as provided in §1903(a) of the Act. Activities such as utilization review, prior authorization and nursing home preadmission screening may be paid as an administrative expense. The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, when the criteria in 42 CFR 432.50 are met.

3. Section 1915(b) Waivers.--Case management may be provided in a waiver granted under §1915(b) of the Act. Section 1915(b) provides that a State may request that the Secretary waive the requirements of §1902 of the Act, including the freedom of choice requirements in §1902(a)(23), if necessary to implement a primary care case management system as described in 42 CFR 431.55(c).

To qualify for such a waiver, the case management project must be cost effective, efficient, and consistent with the objectives of the Medicaid program. The waiver is needed to restrict the provider from (or through) whom an eligible individual can obtain medical care services (other than in emergency circumstances), provided the restriction does not substantially impair access to services of adequate quality, and that the statutory and regulatory requirements for waiver approvals are met. Upon the written request of the State, case management services furnished on or after April 7, 1986 pursuant to a waiver granted under §1915(b)(1) may be reimbursed at the FMAP rate when these services are performed by a vendor. Because of the nature of case management services under a §1915(b)(1) waiver, this activity, when performed by an employee of the Medicaid agency, is construed as necessary for the proper and efficient administration of the State plan and is therefore an administrative expense.

4. Section 1915(c) Waivers.--Case management may be provided as a service in a waiver granted pursuant to §1915(c) of the Act. Section 1915(c)(4)(B) specifically enumerates case management as a service which may be provided as part of a home and community-based services waiver. In order to provide this service, you must define it as part of a waiver request, and identify the qualifications of the providers. Under such a waiver, case management services must be provided under a written plan of care which is subject to the approval of the State Medicaid agency. Services provided in this fashion are reimbursed at the FMAP rate. Section 4440 supplies additional information concerning home and community-based services waivers.

NOTE: The enactment of P.L. 99-272 and P.L. 99-514 has not altered your authority to provide any of the previous categories of case management.

B. Legislation.--P.L. 99-272 adds case management to the list of optional services which may be provided under Medicaid. Section 9508 of P.L. 99-272 adds a new subsection (g) to §1915 of the Act. This subsection, as amended by P.L. 100-203, provides that:

"(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS); or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services."

In authorizing States to offer case management services, Congress recognized that there was some potential for duplicate payments because the same or similar services have often been provided by other programs or under the Medicaid program itself. H. Rep. No. 453, 99th Cong., 1st Session 546 (1985), which accompanies this portion of P.L. 99-272, emphasizes that payment for case management services under §1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

FFP is available at the FMAP rate for targeted case management services rendered on or after April 7, 1986, when these services are included in the State plan.

C. Technical Statutory Change.--Section 1895(c)(3) of the Tax Reform Act of 1986 adds case management services to §1905(a)(19) of the Act. In so doing, it defines §1905(a)(19) in terms of §1915(g)(2).

D. Purpose.--The purpose of these instructions is to implement these sections of the statute, and to provide clarification regarding the requirements of the statute and how they may be met.

4302.1 Case Management Services - Process.--

A. Applicability.--The process described in this section applies to case management services, as described in §1905(a)(19) and §1915(g) of the Act.

B. Submission and Timeframes.--Case management under either §1905(a)(19) or §1915(g) is an optional service under Medicaid. To provide the service, incorporate it into your Medicaid State Plan by means of a State plan amendment submitted to your servicing regional office. As with all State plan amendments that provide additional services, the effective date may be no earlier than the first day of the calendar quarter in which the amendment is submitted. In no case may FFP be claimed for case management services under §1915(g) provided prior to April 7, 1986.

In order to provide services under §1915(g), submit a separate amendment for each target group. There is no limit to the number or size of target groups to whom you may provide case management services. The target group may be the State's entire Medicaid population.

4302.2 State Plan Amendment Requirements.--Any State plan amendment request to provide optional case management services must address all of the requirements of this section.

A. Target Group.--Identify the target group to whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition (e.g., Acquired Immune Deficiency Syndrome (AIDS) or Chronic Mental Illness), or any other identifiable characteristic or combination thereof. The following examples are target groups currently receiving case management services under §1915(g) of the Act:

- o Developmentally disabled persons (as defined by the State);
- o Children between the ages of birth and up to age 3 who are experiencing developmental delays or disorder behaviors as measured and verified by diagnostic instruments and procedures;
- o Pregnant women and infants up to age 1;
- o Individuals with hemophilia;
- o Individuals 60 years of age or older who have two or more physical or mental diagnoses which result in a need for two or more services; and
- o Individuals with AIDS or HIV related disorders.

In defining the target group, you must be specific and delineate all characteristics of the population.

B. Comparability.--Unless you intend to provide case management services in the same amount, duration and scope to all eligible recipients, indicate that §1915(g)(1) of the Act is invoked to provide these services without regard to the requirements of §1902(a)(10)(B) of the Act. (See 42 CFR 440.240.) The exception to comparability requirements applies only to case management services under §1915(g) of the Act. Comparability requirements relating to all other Medicaid services are unaffected by this section.

C. Statewide Availability.--Indicate whether case management services are available to the target group statewide or whether the authority of §1915(g)(1) of the Act is invoked to provide case management services to the target group on a less than statewide basis. If case management services are not to be provided on a statewide basis, indicate the geographic areas or political subdivisions to be served. The provision of targeted case management services on a less than statewide basis does not excuse you from the requirements of §1902(a)(1) of the Act (see 42 CFR 431.50) in regard to the statewide availability of other Medicaid services.

D. Freedom of Choice.--Section 1915(g)(1) of the Act specifies that there shall be no restriction on free choice of qualified providers, in violation of §1902(a)(23) of the Act. Assure that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, assure that case management services will not restrict an individual's free choice of providers of other Medicaid services.

In order to meet the freedom of choice requirements, you must provide for the following:

1. Option to Receive Services.--The receipt of case management services must be at the option of the individual included in the target population. A recipient cannot be forced to receive case management services for which he or she might be eligible.

2. Free Choice of Providers.--Except as indicated for individuals with developmental disabilities or chronic mental illness, an eligible individual must be free to receive case management services from any qualified provider of these services. The recipient may not be limited to case management providers in a clinic, even if the individual receives all other Medicaid services through that clinic. However, in situations where the State has chosen to provide case management services on a less than statewide basis, free choice of the qualified providers is limited to those providers located within all of the identified geographic areas or political subdivisions, as specified in the State plan.

When providing case management services to individuals with developmental disabilities or with chronic mental illness, you may limit the case managers available. This ensures that the case managers for these individuals are capable of providing the full range of needed services to these targeted recipients. This limitation is permissible only with regard to the target groups of developmentally disabled or chronically mentally ill, or any subgroups that you choose to define. If you choose to target a subgroup of individuals who are developmentally disabled or chronically mentally ill, the targeted group (e.g., based on age, degree of impairment) must continue to fit the definition of chronic mental illness or developmental disability. The requirements discussed in items D.1, D.3, and D.4 continue to apply to all target groups.

3. Provider Participation.--Any person or entity meeting State standards for the provision of case management services who wishes to become a Medicaid provider of those services must be given the opportunity to do so. However, the State is not required to extend provider participation to providers located outside the geographic areas in which case management is targeted.

4. Unrestricted Access.--Case management services under §1915(g) of the Act may not be used to restrict the access of the client to other services available under the State plan. This option is, however, available through waivers granted pursuant to §1915(b) of the Act. (See §2100.)

E. Qualifications of Providers.--The statute does not set minimum standards for the provision of case management services. Therefore, establish the minimum qualifications for the providers of case management services. The qualifications set must be reasonably related to the case management functions that a provider is expected to perform. While reasonable provider qualifications are necessary to assure that case managers are capable of rendering services of acceptable quality, use caution in determining the acceptable degree of such qualifications. With the exception of providers of case management services to individuals with developmental disabilities or chronic mental illness, provider qualifications must not restrict the potential providers of case management services to only those viewed as most qualified. Individuals within the specified target group must be free to receive case management services from any qualified provider.

Except as discussed in item D.2, you may not limit the provision of these services to State or other public agencies, but must permit any person or entity that meets the established qualifications in accordance with 42 CFR 431.51(b) to become a Medicaid provider.

F. Nonduplication of Payments.--Payment for case management services under §1915(g) of the Act may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

In general, payment may not be made for services for which another payer is liable. Exceptions to this general rule include payments for prenatal or preventive pediatric care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; payments for services covered under a plan for an individual for whom child support enforcement is being carried out; or any payments made through a waiver granted under the cost effectiveness provisions of 42 CFR 433.139(e). Another major exception is that payments may be made to State education agencies to cover the costs of services provided under a recipient's Individualized Education Program.

Payment may not be made for services for which no payment liability is incurred. Similarly, separate payment cannot be made for similar services which are an integral and inseparable part of another Medicaid covered service.

G. Differentiation Between Targeted Case Management Services and Case Management Type Activities for Which Administrative Federal Match May Be Claimed.--You must differentiate between case management services which may properly be claimed at the service match under §1915(g) and case management activities which are appropriate for FFP at the administrative match under the State plan, based upon the appropriate criteria. These two payment authorities do not result in mutually exclusive types of services.

There are certain case management activities which may appropriately be eligible for FFP at either the administrative or the service match rate. Examples of case management activities that may be claimed at either the administrative or the service match rate entail providing assistance to individuals to gain access to services listed in the State plan, including medical care and transportation. In cases where an activity may qualify as either a Medicaid service or an administrative activity, you may classify the function in either category. This decision must be made prior to claiming FFP because of the different rules which apply to each type of function under the Medicaid program.

1. Case Management as a Service Under §1915(g).--FFP is available at the FMAP rate for allowable case management services under §1915(g) when the following requirements are met:

- o Expenditures are made on behalf of eligible recipients included in the target group (i.e. there must be an identifiable charge related to an identifiable service provided to a recipient);

- o Case management services are provided as they are defined in the approved State plan;

- o Case management services are furnished by individuals or entities with whom the Medicaid agency has in effect a provider agreement;

- o Case management services are furnished to assist an individual in gaining or coordinating access to needed services; and

- o Payment for services is made following the receipt of a valid provider claim. Providers must maintain case records which indicate all contacts with and on behalf of recipients. The case records must document name of recipient, the date of service, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service delivery. In addition, providers must develop a billing system to appropriately identify and bill all liable third parties.

Because §1915(g) of the Act defines case management services as services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan. The costs of case management services provided under §1915(g) that involve gaining access to non-Medicaid services are eligible for FFP at the service match rate.

Examples of case management services provided under §1915(g) of the Act may include assistance in obtaining Food Stamps, energy assistance, emergency housing, or legal services. All case management services provided as medical assistance pursuant to §1915(g) of the Act must be described in the State plan. In addition, they must be provided by a qualified provider as defined in the State plan.

When case management is provided pursuant to §1915(g) of the Act, the service is subject to the rules pertaining to all Medicaid services. If you choose to cover targeted case management services under your State plan, as defined in §1915(g) of the Act, you cannot claim FFP at the administrative rate for the same types of services furnished to the same target group.

NOTE: Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred.

2. Case Management as an Administrative Activity.--Case management activities may be considered allowable administrative costs of the Medicaid program when the following requirements are met:

- o They are provided in a manner consistent with simplicity of administration and the best interest of the recipient, as prescribed by §1902(a)(19) of the Act; and

- o Documentation maintained in support of the claim is sufficiently detailed to permit HCFA to determine whether the activities are necessary for the proper and efficient administration of the State plan, as provided by §1903(a) of the Act.

The following list of functions provides examples of activities which may properly be claimed as administrative case management activities, but not as targeted case management services. The omission of any particular function from this list does not represent a determination on HCFA's part that the function is not necessary for the administration of the plan.

- o Medicaid eligibility determinations and redeterminations;
- o Medicaid intake processing;
- o Medicaid preadmission screening for inpatient care;
- o Prior authorization for Medicaid services and utilization review;

and

- o Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system).

Because activities related to services which Medicaid does not cover are not considered necessary for the administration of the Medicaid plan, the accompanying costs are not eligible for Medicaid FFP at the administrative rate. For example, case management related to obtaining social services, Food Stamps, energy assistance, or housing cannot be considered a legitimate Medicaid administrative expense even though it may produce results which are in the best interest of the recipient. These services can be provided as medical assistance if described in the State plan.

Similarly, setting up an appointment with a Medicaid participating physician and arranging for transportation for a recipient may be considered case management administrative activities necessary for the proper and efficient administration of the Medicaid plan. However, arranging for baby sitting for a recipient's child, although beneficial to the recipient, is not an activity for which administrative FFP can be claimed.

In addition, when a caseworker suspects that physical abuse of a recipient has occurred, the referral to medical care could be considered a reimbursable administrative activity under the Medicaid program. However, assisting the victim in obtaining emergency housing and legal services, although in the best interest of the recipient, is not an activity for which administrative FFP may be claimed. In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State's claims for Federal funds under the appropriate authorities.

Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

When a State expects to claim FFP for Medicaid administrative case management activities, the costs for these activities must be included in a cost allocation plan submitted to and approved by your HCFA RO. HCFA reserves the right to evaluate the activities for which FFP is claimed to determine whether they meet the requirements (either administrative or service match) for payment. When FFP is claimed for any functions performed as case management administrative activities under §1903(a) of the Act, documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

H. Case Management Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.--Care coordination, including aspects of case management, has always been an integral component of the EPSDT program, as described in 42 CFR 441.61. OBRA 1989 (P.L. 101-239) modified the EPSDT program by adding §1905(r) to the Act. Section 1905(r) requires that States provide any services included in §1905(a) of the Act, when medical necessity for the service is shown by an EPSDT screen, whether such services are covered under the State plan. While case management is required under the expanded EPSDT program when the need for the activity is found medically necessary, this does not mean §1915(g) targeted case management services. Therefore, when the need for case management activities is found to be medically necessary, the State has several options to pursue:

1. Component of an Existing Service.--Case management services may be provided to persons participating in the EPSDT program by an existing service provider such as a physician or clinic referring the child to a specialist.

2. Administration.--Case management services may be provided to EPSDT participants by the Medicaid agency or another State agency such as title V, the Health Department or an entity with which the Medicaid agency has an interagency agreement. Administrative case management activities must be found necessary for the proper and efficient administration of the State plan and therefore must be limited to those activities necessary for the proper and efficient administration of Medicaid covered services. FFP is available at the administrative rate.

3. Medical Assistance.--Case management services may be provided under the authority of §1905(a)(19) of the Act. The service must meet the statutory definition of case management services, as defined by §1915(g) of the Act. Therefore, FFP is available for assisting recipients in gaining access to both Medicaid and non-Medicaid services. FFP for case management services furnished under §1905(a)(19) of the Act is available at the FMAP rate.

Any combination of two or more of the above is possible, as long as FFP is not available for duplication of services.

I. Service Limitations.--The following are not allowable targeted case management services as defined in §1915(g)(2) of the Act.

1. Other Medicaid Services.--When assessing an individual's need for services includes a physical or psychological examination or evaluation, bill for the examination or evaluation under the appropriate medical service category. Referral for such services may be considered a component of case management services, but the actual provision of the service does not constitute case management.

2. Referral for Treatment.--When an assessment indicates the need for medical treatment, referral or arrangements for such treatment may be included as case management services, but the actual treatment may not be considered.

3. Institutional Discharge Planning.--Discharge planning is required as a condition for payment of hospital, NF and ICF/MR services. Therefore, this cannot be billed separately as a targeted case management service.

4. Client Outreach.--Outreach activities in which a State agency or a provider attempts to contact potential recipients of a service do not constitute case management services. The statute defines case management services as, "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services" (emphasis added). The attempt to contact individuals who may or may not be eligible for case management services does not fall under this definition. However, such outreach activities may be considered necessary for the proper and efficient administration of the Medicaid State plan. When this is the case, FFP is available at the administrative rate.

J. Coordination With Home and Community-Based Services Waivers.--Case management services continue to be available under home and community-based services waivers approved pursuant to §1915(c) of the Act. However, since approval for §1915(c) waiver services may only be granted for services not otherwise available under the State plan, the addition of case management services under the State plan may necessitate the modification of a home and community-based services waiver. In order to comply with the nonduplication of services requirements discussed in §4302B, the following elements apply to waivers under §1915(c).

1. Service Not Included in Waiver.--Home and community-based services waivers (and requests for waivers) which do not contain case management as a waiver service are not affected by this section.

2. Different Target Population.--Home and community-based services waivers (and requests for waivers) which are targeted at a population different from the group(s) to whom targeted case management services are provided are not affected by this section.

3. Duplication of State Plan Service.--When a home and community-based services waiver contains case management as a waiver service and the State adds case management services to the State plan, the following apply:

a. Same Target Population and Service Definition.--If the target population and the service definitions are the same, delete the case management services from the waiver through an amendment request, and make appropriate cost and utilization adjustments to the waiver cost effectiveness formula.

b. Same Service Definition.--If the definition of services is the same, but only a portion of waiver recipients (who receive waiver case management) are now eligible for the State plan service, the service may remain in the waiver. Adjustments must be made to the cost effectiveness formula to reflect the fact that a number of recipients now receive the State plan service.

4. Same Target Population.--If you have targeted case management services in your State plan for a particular group, and you submit a waiver request for the same targeted group, the request for waiver may not include case management services through the waiver under the same definition used in the State plan. If the case management is provided under an identical definition, it must be provided under the State plan and not under the waiver.

K. Payment Methodology.--The amendment must specify the methodology by which payments and rates are made. Indicate the payment methodology for public as well as private providers. Enter this information on attachment 4.19-B of the State plan.

L. Documentation of Claims for Case Management Services.--In order to receive payment for case management services under the plan (i.e., at the FMAP rate), fully document your claim as you do for any other Medicaid service. If you pay for case management services through capitation or prepaid health plans, the requirements of 42 CFR Part 434 must be met. With the exception of claims paid under capitation or prepaid health plan arrangements, you must document the following:

- o date of service,
- o name of recipient,
- o name of provider agency and person providing the service,
- o nature, extent, or units of service, and
- o place of service.

NOTE: While forms of documentation such as time studies, random moment sampling and cost allocation plans may be appropriate for claiming administrative FFP for activities in support of the State plan, these modes of documentation are not acceptable as a basis for Federal participation in the costs of Medicaid services. There must be an identifiable charge related to an identifiable service provided to a recipient.

4302.3 Instructions For Completing Preprint Supplement.--

A. State Plan Amendment.--To include case management services in your State plan, indicate your intentions on Attachment 3.1-A and 3.1-B of the State plan preprint. In addition, complete one preprint supplement for each target group to whom the services will be provided. (OMB approval is required under the Paper Work Reduction Act of 1980 and will be obtained.)

B. Supplement 1 to Attachment 3.1-A.--Exhibit 1 is a copy of supplement 1 to Attachment 3.1-A. Each item must be completed for the amendment to be approved.

Item 1. Define the target group. Indicate any limitations of disease or condition, age, institutional or noninstitutional status or other characteristic(s) by which the target group is identified.

Item 2. Check one category. If services are provided on a less than statewide basis, specify the geographic areas or political subdivisions to which the services will be provided.

Item 3. Check one category.

Item 4. Define case management services as they apply to the target population. Specify any limitations that apply. Indicate the unit(s) of service. Identify any coordination with non-Medicaid programs or agencies.

Item 5. Specify the qualifications of the providers. These qualifications must be reasonably related to the case management function(s) that the providers are expected to perform.

Item 6. No information necessary.

Item 7. No information necessary.

EXHIBIT I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

CASE MANAGEMENT SERVICES

A. Target Group:

B. Areas of State in Which Services Will Be Provided:

Entire State

Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

Services are provided in accordance with §1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

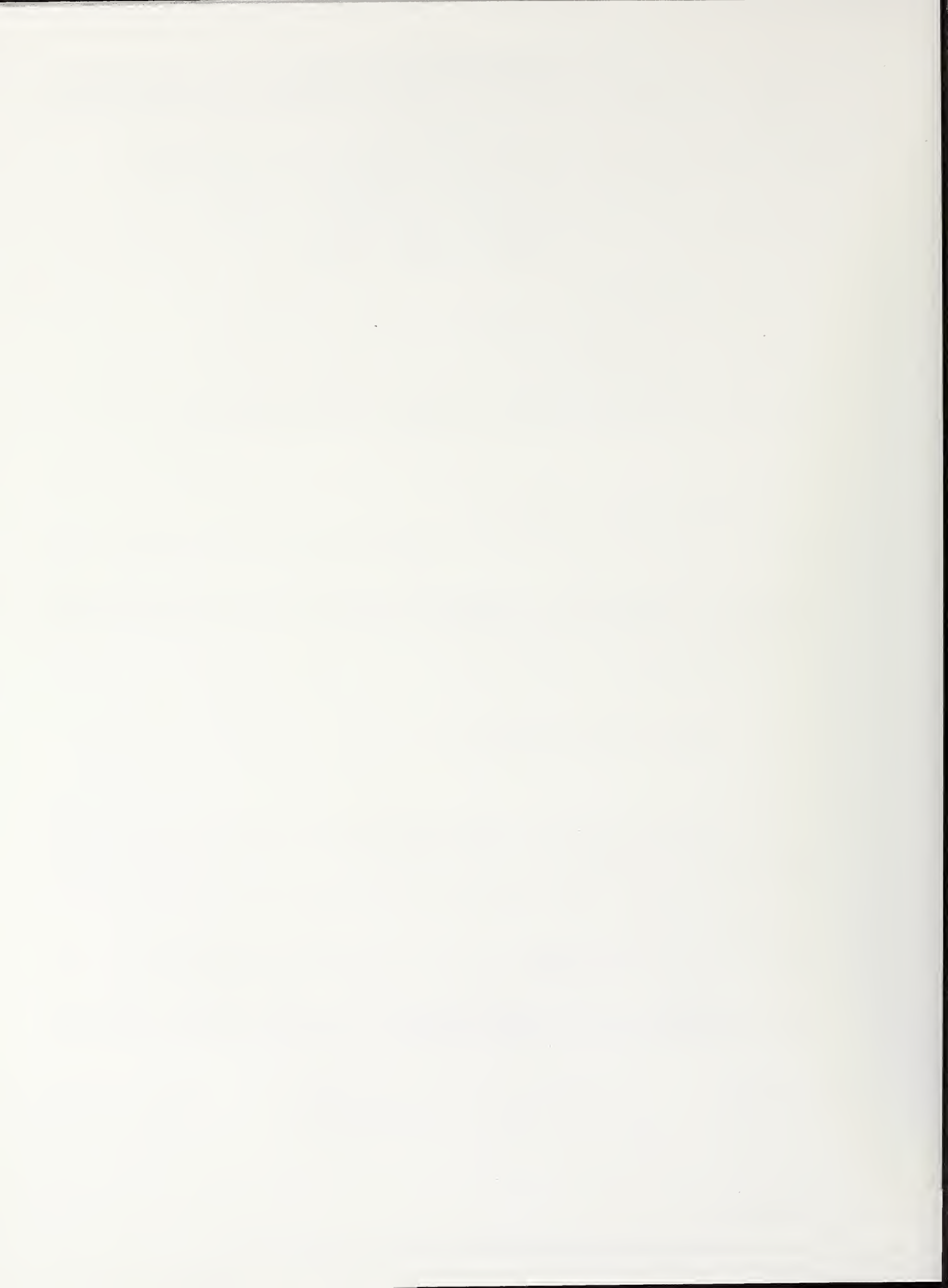
E. Qualifications of Providers:

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.



Appendix B
Excerpts from *Section 1915(b) Waivers—*
Guide to Best Practices*

* This appendix contains edited excerpts from the 1992 report of the Health Care Financing Administration, Medicaid Bureau.



Introduction

This guide is intended for use by state Medicaid agencies interested in finding innovative ways to foster the delivery of health care services to their Medicaid populations through the use of freedom-of-choice waivers under the authority of Section 1915(b) of the Social Security Act.

Freedom-of-choice waiver programs have saved states and the federal government several million dollars since they were first authorized by the Omnibus Budget Reconciliation Act of 1981. While these cost savings were the first benefit identified through the use of these waivers, enhanced recipient access to primary care services and other benefits often have been realized.

With limited exceptions, states may request waiver of any of the provisions in Section 1902 of the Social Security Act necessary to implement the desired program. Most often, states request waiver of Section 1902(a)(23) on recipient freedom of choice, along with Section 1902(a)(1) on statewideness, and Section 1902(a)(10) on comparability of services. In requesting freedom-of-choice waivers, states must document that the program will be cost-effective (within the two-year approval period), that it will not substantially impair recipients' access to care of adequate quality, that it will not restrict access to emergency or family planning services, and that it will be consistent with the purpose of the Medicaid program in accordance with 42 CFR 431.55(b). The documentation required for each of these specific requirements as well as the process for requesting a waiver is further described in Sections 2105 to 2112 of the Health Care Financing Administration's *State Medicaid Manual*.

The four provisions under which waivers may be requested are described below. A waiver request may involve one or more of these provisions depending on how the specific waiver program is designed.

Section 1915(b) Waivers

Section 1915(b)(1)—Primary Care Case Management Systems (PCCM) or Specialty Physician Services Arrangements. Under a PCCM, a state must ensure that a specific person or persons or a clinic or agency (the case manager) will be responsible for locating, coordinating, and monitoring all primary care and other medical care and rehabilitative services covered under the waiver on behalf of recipients enrolled with that case manager. Primary care is ordinarily provided by family practice physicians, internists, pediatricians, obstetricians, or physician surrogates (e.g., physician assistants, nurse practitioners, and pediatric associates), and may include the provision of, or arrangements for, all services available under the state plan as long as primary care services also are provided.

A specialty physician services arrangement permits a state to restrict recipients of specialty services to designated providers (e.g., those in need of maternity-related or mental health services to specific clinics providing the services required).

Section 1915(b)(2)—Locality as a Central Broker. A Section 1915(b)(2) waiver permits a state to use a locality as a central broker to assist recipients as they select among competing health plans by providing them with more information about the range of health care options open to them. Under this provision, a locality is any

defined jurisdiction. It may utilize any agency or agent to act on its behalf in carrying out its central broker function. In practice, this provision is used in conjunction with a waiver under Section 1915(b)(1) to help recipients choose among the options available to them under the (b)(1) waiver program.

Section 1915(b)(3)—Sharing of Cost Savings with Recipients. Section 1915(b)(3) permits a state to share with recipients cost savings that have resulted from the use of cost-effective medical care. These savings may be shared by providing additional services not otherwise available to recipients, or by eliminating copayments or limitations on services. These services may include those offered by plans selected by recipients or those offered expressly by the state as an inducement for recipients to participate in a PCCM under Section 1915(b)(1), a competing health plan, or any other arrangements that result in cost-effective medical care. This waiver also is used in conjunction with waiver authority under Section 1915(b)(1).

Section 1915(b)(4)—Restriction of Recipients to Specified Providers. Section 1915(b)(4) permits a state to require recipients to obtain services only from specified providers that undertake to provide such services and meet specific reimbursement, quality, and utilization standards. This provision actually allows a state to permit the participation of a limited number of specified providers of any type, while excluding the remaining providers that otherwise would be qualified to participate in Medicaid. However, this restriction on providers may not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the services in question. In this context, demonstrated effectiveness and efficiency refer to reducing costs or slowing the rate of increase of costs and maximizing outputs or outcomes per unit of cost.

Thus, providers that are able to provide the same services at a reduced cost to the Medicaid program, or that are more effective at providing the services resulting in better outcomes and greater efficiency for the Medicaid program may operate under one of these waivers, while their less effective or efficient (but otherwise qualified) counterparts may not.

This waiver authority is used in two ways. The first is for selective provider contracting, where a state has more than the necessary number of a certain type of provider to serve its Medicaid population. With the authority, a state can contract with specified providers of a given type that agree to accept rates lower than those in the state plan, or that would be accepted by other providers of that type. Recipients in any contracting areas would be limited to obtaining services from contracting providers (except in emergencies).

The second way this authority may be used is in conjunction with Section 1915(b)(1), where specified recipients in a case managed waiver may be restricted to providers meeting the requirements for treating these recipients (e.g., restricting high-risk pregnant women to board-certified obstetricians/gynecologists and delivery in Level II or Level III hospitals).

These two ways that the authority in Section 1915(b)(4) may be used parallel the two general types of waiver programs—Managed Care Programs and Selective Provider Contracting Programs. These are discussed in detail, with examples of current programs, in the sections that follow.

Consultation with Provider and Recipient Groups

One common thread in all successful waiver programs is that the program is defined to fit the recipient and provider needs in the area in which it operates. States that have been most successful have spent a lot of time and effort in consultation with provider and recipient groups before formulating a waiver request. A state may begin by being mindful of the goals it wishes to achieve (e.g., enhancing recipient access to primary care, reducing unnecessary Medicaid expenditures, and promoting continuity of care through case management). However, it may not be possible to implement such a program absent full awareness of the current health care delivery system concerns and without receptiveness to the state's ideas—along with some idea of the willingness of providers to support the program and an understanding of recipient needs and concerns.

Promoting a program while still developing the specifics of operation can be very helpful. Once a state is convinced that providers are on board, a state can explain the benefits of a particular program to its Medicaid recipients (e.g., how they can gain access to their own personal physician). Information from advisory groups, public service announcements, advertising, and educational programs are all used in various states to both promote the programs and to obtain feedback on program design and operation from those most directly affected.

Coordinated Care Waivers

Virtually all waivers offering managed care for a state's Medicaid population operate under the authority of Section 1915(b)(1) of the act. These programs comprise the vast majority of the eleven approved 1915(b) waivers that are currently operational. They vary by services offered, population targeted, recipient enrollment (voluntary versus mandatory), reimbursement mechanisms, and other program design issues.

Services Offered. In general, the focus of the services offered under the waiver will depend upon the population that is targeted. While Alabama and South Carolina both target pregnant women, in South Carolina only those pregnant women and infants identified as high risk are treated under the waiver program. South Carolina and Utah have waivers targeted to the population in need of mental health services. Minnesota has a program targeted toward substance abuse and chemical dependency. New York and Tennessee each have waiver programs for pediatric care.

Most managed care waivers are focused on primary care case management, where a provider of services is responsible for the provision of a recipient's primary care, and coordinates, locates, and refers the recipient for other types of care. Recipients enrolled in these programs have a case manager, who may be an individual practitioner, physician group, clinic, or agency responsible for their medical care. Through these systems recipients may be channeled from less appropriate into more appropriate treatment sites (e.g., from the hospital emergency room to the physician's office), establishing a relationship with a primary provider that may not have been possible previously, and obtain continuity of care rather than the episodic care they were receiving beforehand.

Regardless of the reimbursement mechanism used, states have found that primary care physicians are more willing to participate in Medicaid when they have

some control over the recipient's medical care. The restriction on freedom of choice helps prevent recipients from doctor shopping, obtaining multiple tests and prescriptions for the same condition, and from self-referring to specialists.

Recipient Enrollment. Recipient participation in Section 1915(b) waiver programs is either voluntary or involuntary, though even where participation is required, some programs provide for exceptions to mandatory participation for demonstrations of good cause.

Most currently operational 1915(b) programs require the participation of either all recipients (or all of those in designated eligibility categories). Most of these programs involve the state's AFDC population, where greater savings appear possible. The two maternity-related programs mentioned above (Alabama and South Carolina) require participation in the waiver, but permit recipients to request an exemption based on concerns such as travel times to waiver providers or physical distress caused by travel, or for continuity of care due to a pre-existing relationship with a non-waiver provider.

Generally excluded from waiver participation are residents of long-term care facilities, recipients eligible on the basis of spend-down, and dual Medicare/Medicaid eligibles. Where recipients are entitled to Medicare coverage in addition to their Medicaid entitlement, Medicare is the primary payor and no restrictions on their Medicare freedom of choice are permitted through the use of Section 1915(b) waivers.

A number of states with 1915(b)(1) programs permit recipients to enroll in HMOs that are operational in the waiver service area but not part of the freedom-of-choice waiver. These states, which include Colorado, Florida, Oregon, and Pennsylvania, specifically exempt HMO enrollees from participation in the waiver. Of course, if the recipient disenrolls from the HMO, he or she would automatically become a waiver participant and be subject to all requirements of that waiver program. This option guarantees a choice for recipients, while allowing the state to use HMO enrollment as another managed care option without the need to include all HMO-related data in waiver requests and renewals.

HMO enrollment and disenrollment and other rules are governed by Section 1903(m) of the act, which may *not* be waived under Section 1915(b). Thus, the only thing a state has to gain by including the HMO in this type of program is an increase in the amount of cost-effectiveness of the overall waiver program due to contracting with the HMO at a rate less than 100 percent of the upper payment limit.

Section 1915(b)(1) waiver programs operate with voluntary enrollment in California, New York, and Tennessee. In one of New York's programs and in Tennessee, the waivers are only open to children, while all recipients may enroll in the other programs. One advantage of voluntary enrollment programs is the ability to offer a managed care alternative without requiring it where other options may not be available. A relatively simple measure of quality and access under a voluntary program would be the volume of, and reasons for, recipient disenrollments from the waiver program.

Voluntary programs can present serious problems for states in documenting the cost-effectiveness of a waiver for a number of reasons. First is the possibility that only

the healthier populations would be enrolled in the waiver program. Since the upper payment limit in capitated programs is based on the fee-for-service costs for a comparable population, the question may be raised as to whether the remaining non-enrolled population in any given area is comparable to the population under the waiver. If it is likely, or even possible, that only those people more concerned about good health will enroll in the waiver program, how can the costs of the remaining population ever be used for a valid comparison (whether under capitation or fee for service)?

Further, if the healthier (and therefore less costly) population is enrolled in a capitated waiver, while the less healthy population is enrolled under fee for service, the disparity between the capitation rate (based on the upper payment limit for the costs of the sicker population) and the cost of care that would have been incurred for the enrolled population could continue to grow each year as the rate is computed.

Conversely, if the opposite were true (the less healthy population were enrolled while the healthier population was not), it would be very difficult to show savings under a fee-for-service system, or to continue contracting at a rate based on the upper payment limit under a capitated system.

Therefore, it appears that whenever there are sufficient providers to meet access requirements and to permit changing case managers or disenrolling from contractors within a designated waiver area, mandatory enrollment is preferable to voluntary enrollment. Mandatory enrollment *requires* a state to obtain waiver authority. Recipients may be voluntarily enrolled under Section 1915(a) exceptions, or under state plan provisions for PHPs and HMOs.

Provider Reimbursement. Managed care waiver programs may be reimbursed through fee for service, capitation, a combination of the two, or through some other methodology such as in Alabama's Maternity Waiver, where an enhanced global fee is used. There are advantages to each of these reimbursement arrangements.

States using fee-for-service reimbursement generally pay a monthly fee to the physician case manager for each enrollee in his or her care. Kentucky's KenPAC program and most others pay \$3 per month for the case management fee. Under Maryland's recently approved MAC program, however, the state allocated the aggregate amount it would have paid in case management fees to an increase in physician fees. (This was suggested by the physician association within the state, again illustrating the importance of consulting with provider groups even in the initial planning stages.)

The main advantage to fee-for-service reimbursement is that a state may continue to use the existing fee schedules under the pre-existing state plan. There is no need for the development of area and recipient category-specific upper payment limits and capitation rates. Fee-for-service reimbursement already is understood and accepted by the provider community, while capitation may not be acceptable to some providers in some areas. Cost-effectiveness will be based upon reductions in utilization, for example, by using units per eligible, which eliminates some of the variables involved in other cost comparisons. And while the amount of savings may be relatively small, payments under a fee-for-service arrangement are made on a delayed basis, while capitation rates are paid at the beginning of each month for that month's enrollment.

There also are a number of benefits wherever a state can enter into a fully capitated system. Savings will be achieved up front, by paying a contractor a rate less than 100 percent of the upper payment limit. Assuming that a state calculates the upper payment limit correctly, it guarantees itself a designated margin of savings. Further, the state will know how much it is going to spend in the entire contract year for the recipients covered under the waiver since, with the exception of any stop-loss limits or risk sharing arrangement, its costs are limited to the capitation rates paid.

In addition, with a fully capitated system, a state will no longer need to process claims under fee for service for the enrolled population, resulting in additional savings. Finally, while effective case management under fee-for-service waivers is based solely on the good faith performance of physician case managers (and follow-up by the state), there are financial incentives to control costs in a capitated system. Of course, additional quality assurance monitoring may be necessary to ensure that there is not underutilization under such systems. And, fully capitated systems require contracting with HMOs, which are not available to all states in all areas.

Partially capitated systems offer some of the advantages of both fee-for-service and full capitation systems. California's Primary Care Case Management system, New York's Physician Case Management Program, and Oregon's Physician Care Organizations are examples of this arrangement. With a partially capitated system, a state contracts with a physician, physician group, or clinic for a limited range of services under capitation. This contract may *not* be risk comprehensive; that is, the contractor may not be at risk for inpatient hospital services and any one of the following, or for three or more of the following services or groups of services:

- outpatient hospital services and rural health clinic services;
- other laboratory and X-ray services;
- skilled nursing facility services, EPSDT, and family planning;
- physicians' services; or
- home health services.

In these partially capitated programs, the contractor usually is made at risk for physician services and either laboratory and X-ray or clinic services. All remaining services are reimbursed under fee for service. Accounts are kept of the fee-for-service costs for each provider's enrollees in areas such as inpatient hospital, outpatient hospital, pharmacy, and referral physician costs, and savings from fee-for-service utilization are shared with the contractor. Thus, contractors have a financial incentive to be effective case managers without being fully at risk for the range of services that normally would require contracting with an HMO.

This arrangement preserves the traditional physician role, while maintaining fee-for-service reimbursement for most state plan services and obtaining financial incentives usually available only with HMOs. Administratively, a state must continue to process most fee-for-service claims, and also to track provider- and recipient-specific utilization and costs, while monitoring against possible underutilization.

An enhanced global fee is the reimbursement mechanism used by Alabama in its Maternity Waiver Program. The state contracts with primary providers that must either

provide or arrange for virtually all of a recipient's prenatal care and postpartum care, including a minimum number of prenatal visits, delivery, and some additional services such as nutritional and social work evaluations and a post-discharge home visit, while case managing the recipient through her pregnancy. The payment to primary providers is based on 97 percent of the projected cost of the services to be provided, plus \$70 for the case management.

While this bundling of services for reimbursement purposes is calculated in a manner similar to the determination of an upper payment limit in capitated systems, the regulations on upper payment limits and capitation do not apply. Savings are built into this mechanism, since the state pays a rate that is less than 100 percent of the fee-for-service cost of the services to be provided. The global fee is only paid to the primary provider after delivery, and with the verification that a minimum number of services (depending upon the trimester in which an individual is first treated) have been provided. The state benefits through the case management of these services; the incentive for providers to provide, at a minimum, the required number of services; and by an overall reduction in the number of claims to be processed.

This type of reimbursement mechanism would only seem appropriate for specific illnesses or conditions such as pregnancy, which is time limited and for which a specific bundle of services or plan of treatment can be readily identified.

The best reimbursement mechanism in any given state depends upon the environment in that state. The importance of consulting with Medicaid providers as early as possible in the planning stages of a waiver program cannot be overstated. Successful waiver programs can be designed and savings achieved with any of the above systems. But without sufficient provider participation, none of them will work.

Miscellaneous Good Practices: In this section aspects contributing to the success of waiver programs are described.

Toll-Free Hotline. In most of the current waiver programs involving coordinated care, states have instituted a toll-free hotline. The hotline can be used by recipients for any questions, complaints, or situations where they have been unable to reach their case manager, requests for reassignment of case manager, or other issues. HealthPASS in Pennsylvania also has instituted a separate hotline for use by providers, particularly for questions on a recipient's eligibility and billing issues.

These hotlines can reduce confusion among participants, particularly with a new program; serve as a quality control mechanism and check on case manager compliance with coverage requirements; reduce the number of grievances and appeals; and solve a number of minor problems before they become major ones.

Identification of Recipient's Case Manager on the Medicaid Card. Having the case manager's name and phone number on the recipient's Medicaid card serves a dual purpose. First, the recipient should always know where to go first when in need of nonemergency medical care. Second, if the recipient should go to an emergency room or another unauthorized provider, it will be clear to the provider that the recipient needs an authorization before nonemergency treatment is provided, from whom that authorization should be obtained, or to whom that recipient should be referred.

Freedom to Change Case Manager. While Section 1903(m) prescribes specific disenrollment rules for HMOs, most waiver programs involve fee-for-service case managers, prepaid health plans, or health insuring organizations, where the state prescribes how a recipient selects and may change his or her case manager through its design of the waiver program. HCFA has permitted states to restrict waiver participants' unrestricted selection of case managers for up to six months, except in instances of good cause. However, while permitting unlimited changes of case managers may place an administrative burden on the state, it can produce long-term benefits for the waiver program.

Since one objective is to enhance access to primary care, it is in a state's interest to have recipients satisfied with their case manager so that it is more likely that they will seek needed primary care from the case manager, and less likely that problems or grievances will arise from recipients. Further, the case manager is one of the keys to the success of a waiver, and recipients' satisfaction in many cases will be based on the perception of the case manager and his or her contacts with recipients.

The tracking of requests for change of case manager also is an effective quality control tool. Patterns of noncompliance with waiver program requirements should be evident from the reasons recipients give for changing case managers (e.g., not providing twenty-four-hour coverage). While case manager shopping may replace doctor shopping by some recipients, there is more to be gained by permitting case manager change than by an overly restrictive policy.

Marketing. While the need for marketing should be obvious when implementing a waiver program, its importance cannot be overemphasized. One waiver program received a complaint that the program was being over-advertised. HCFA interpreted this to mean that there was no lack of awareness or information on the waiver in its service area, and that an excellent job had been done by the state and its contractor.

A state should take every opportunity it can to market a waiver program and educate providers, provider groups, recipients, recipient groups, local offices, local political leaders, its own personnel, and anyone else who could be involved in any way in the operation of the program. Marketing tools include public service announcements, billboards and other advertising, videotapes, and training programs for staff who come in contact with waiver participants. The better all participants (recipients and providers) understand their rights and responsibilities under a waiver program, the smoother the program will run and the more effective it is likely to be.

Other Program Design Issues. Other issues of design will facilitate an effective program. These include encouraging recipients to enroll with individual practitioners rather than outpatient departments or large clinics and expediting the development of a cost comparison system.

Encourage Recipient Enrollment with Individual Practitioners Rather Than Outpatient Departments or Large Clinics. In most coordinated care waiver programs, case managers may be individual practitioners, clinics, health departments, or outpatient departments of hospitals. Since aligning Medicaid recipients with their own personal physician often is a program goal, it is more likely to occur when they are enrolled with an individual practitioner.

In large outpatient departments and clinics it is not always possible for the individual to see the same physician, who may be an intern or resident of the facility. And, effective continuity of care may be less likely. Of course, these providers usually are all necessary in order to guarantee sufficient primary care physician to recipient ratios. HCFA will not approve waivers where this ratio is substantially higher than it would be in the absence of the waiver. (Generally, the maximum allowable ratio would be between 1:1,500 and 1:2,000.)

Expedite Development of a Cost Comparison System. Many states have found it more difficult to obtain a renewal of their waiver authority than it was to obtain the initial two-year approval, particularly in the area of cost-effectiveness. Most of the time, the state has well documented its costs under the waiver but has had difficulty computing the costs it would have incurred in the absence of the waiver, or in finding costs that are comparable to those under the waiver.

With capitated systems, a state may need to develop a population comparable to that under the waiver to determine an actuarially valid upper payment limit. Under fee-for-service programs, a state may need to develop bases for comparison of waiver and nonwaiver costs, such as units per eligible. Whatever type of reimbursement is used under the waiver, the sooner the state develops its system for tracking costs both under the waiver and in the absence of the waiver, the smoother its request for waiver renewal should be.

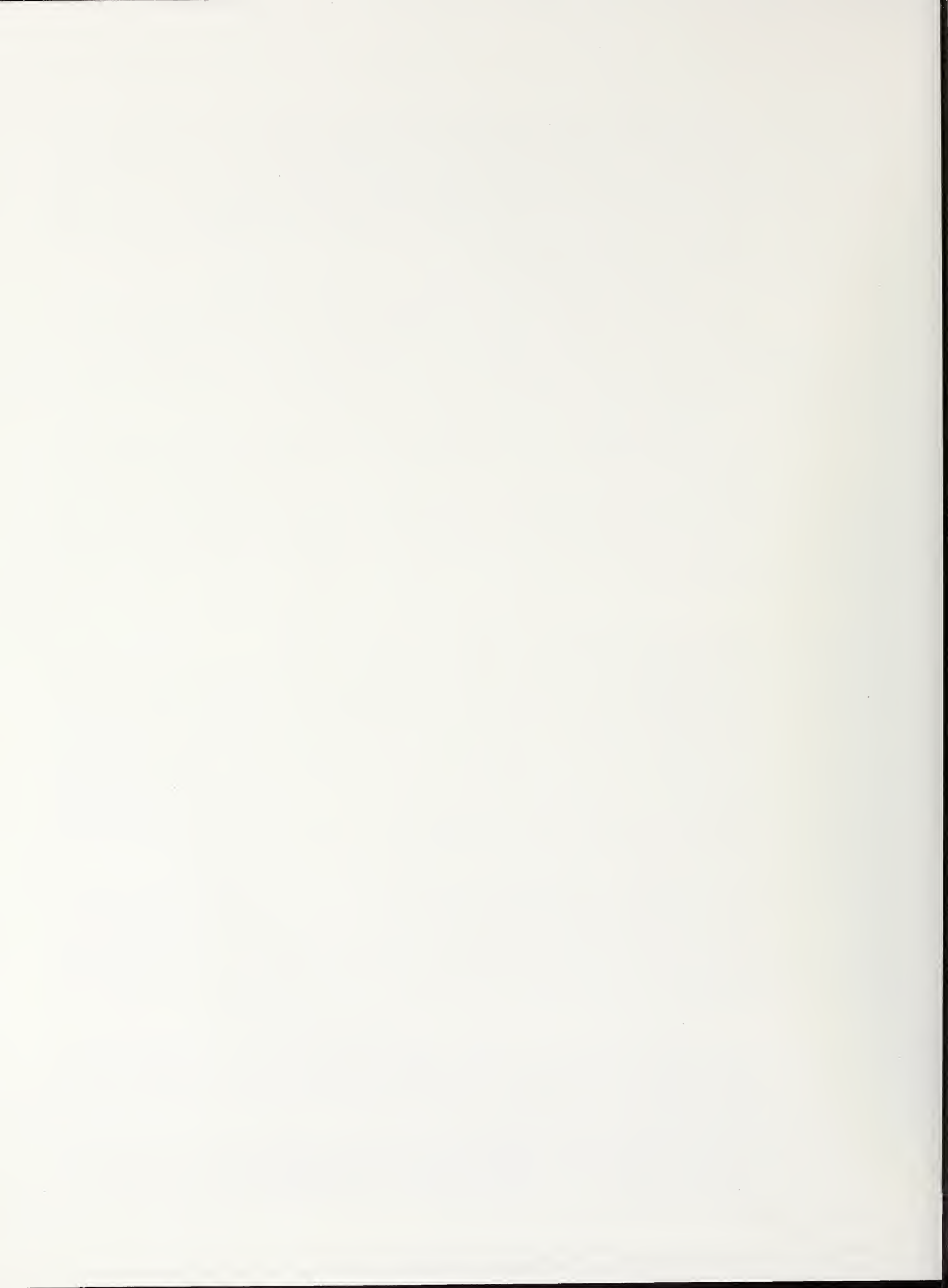
Selective Provider Contracting Waivers

While most Section 1915(b) waiver programs involve coordinated care, there currently are four operational waiver programs involving selected contracting with providers of a specified type. In these programs, states use the authority in Section 1915(b)(4) to contract only with providers that agree to provide services at a rate lower than the rate that would have been paid under the state plan. This restriction of providers may not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the services in question. In this context, demonstrated effectiveness and efficiency refer to reducing costs or slowing the rate of increase of costs and maximizing outputs or outcomes per unit of cost.

California, Illinois, and Washington have contracting waivers for inpatient hospital services. The programs vary, but in each waiver the state projects the number of beds or days of care it will require in the contracting year and negotiates per diem rates with area hospitals until projected needs are met. Recipients must live within accepted community distance/travel standards of participating providers to come under the waiver program.

In Louisiana the state contracts with a single provider of transportation services in several areas through a request for proposal process. In this way, the state is able to select the lowest bidder that meets all minimum standards regarding factors such as the number of vehicles and drivers.

For either of these programs to be successful, a state needs to have more than a sufficient number of providers available, so that there is a competitive climate for Medicaid business that will enable the state to negotiate lower rates with providers.



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